SERFF Tracking Number:	*SEFL-126359476*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*43983*
Company Tracking Number:	*SWL APP*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*SWL App*		
Project Name/Number:	*SWL App/SWL App*		

Filing at a Glance

Company: Assurity Life Insurance Company

Product Name: SWL App	SERFF Tr Num: SEFL-126359476	State: Arkansas
TOI: L07I Individual Life - Whole	SERFF Status: Closed-Approved-Closed	State Tr Num: 43983
Sub-TOI: L07I.101 Fixed/Indeterminate Premium - Single Life	Co Tr Num: SWL APP	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Author: Kristi Hendrickson	Disposition Date: 11/05/2009
	Date Submitted: 11/04/2009	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: SWL App	Status of Filing in Domicile: Authorized
Project Number: SWL App	Date Approved in Domicile: 10/23/2009
Requested Filing Mode: Review & Approval	Domicile Status Comments: Approved
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 11/05/2009	Explanation for Other Group Market Type:
	State Status Changed: 11/05/2009
Deemer Date:	Created By: Kristi Hendrickson
Submitted By: Kristi Hendrickson	Corresponding Filing Tracking Number:

Filing Description:

Form Number; Form Title

47-300-01101 (R10-09); Application for Simplified Life Insurance

Assurity Life Insurance Company submits the above captioned form for review and approval. When approved, the form will replace form 47-300-01101 (R08-08), previously approved by your office on March 19, 2008 under filing number 38434.

SERFF Tracking Number:	*SEFL-126359476*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*43983*
Company Tracking Number:	*SWL APP*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*SWL App*		
Project Name/Number:	*SWL App/SWL App*		

Along with formatting changes to be consistent with our other applications, the Health Section questions have been revised in an effort to clarify the conditions addressed by the questions. The changes have been reviewed from an underwriting and actuarial perspective and will not impact the mortality or pricing of the products applied for with application.

This application will be used to apply for whole life coverage provided by policy form numbers I L601 (AR) and I L602 (AR). These forms were approved by your office on October 12, 2006.

Company and Contact

Filing Contact Information

Kristi Hendrickson, Policy Filing Specialist
1526 K Street
Lincoln, NE 68508

policyfiling@assurity.com
402-437-3452 [Phone]
402-437-3802 [FAX]

Filing Company Information

Assurity Life Insurance Company
1526 K Street
P.O. Box 82533
Lincoln, NE 68501-2533
(800) 276-7619 ext. [Phone]

CoCode: 71439
Group Code: -99
Group Name:
FEIN Number: 38-1843471

State of Domicile: Nebraska
Company Type: Life/Health
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$20.00
Retaliatory?	No
Fee Explanation:	20.00 per form
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Assurity Life Insurance Company	$20.00	11/04/2009	31792935

SERFF Tracking Number:	*SEFL-126359476*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*43983*
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TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*SWL App*		
Project Name/Number:	*SWL App/SWL App*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	11/05/2009	11/05/2009

SERFF Tracking Number:	*SEFL-126359476*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*43983*
Company Tracking Number:	*SWL APP*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*SWL App*		
Project Name/Number:	*SWL App/SWL App*		

Disposition

Disposition Date: 11/05/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*SEFL-126359476*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*43983*
Company Tracking Number:	*SWL APP*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*SWL App*		
Project Name/Number:	*SWL App/SWL App*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Acturial Memo		No
Form	Application for Simplified Life insurance		Yes

SERFF Tracking Number:	*SEFL-126359476*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*43983*
Company Tracking Number:	*SWL APP*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*SWL App*		
Project Name/Number:	*SWL App/SWL App*		

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	47-300-01101 (R10-09)	Application/ Enrollment Form	Application for Simplified Life insurance	Revised	Replaced Form #: 47-300-01101 (R03-08) Previous Filing #: 38434	50.500	47-300-01101 _R10-09_ .pdf

ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(402)476-6500 • (800)276-7619 • FAX (402)437-4591

Application for SIMPLIFIED LIFE INSURANCE

PLEASE PRINT WITH BLACK INK

1. PROPOSED INSURED

First / Middle / Last — Legal Name	Date of Birth (MM/DD/YYYY) / /
Social Security No. ☐ Male ☐ Female — E-Mail	Age
Street Address / City / State / ZIP+4 — Home Address	
Personal Phone No. ( ) — Birth State/ Country	Height ft. in. — Weight lbs.

Has the Proposed Insured ever used any form of tobacco or nicotine-based products, or substitutes such as patches or gum? ..... ☐ Yes ☐ No

If YES, please list type(s): Last date of use / / (MM/DD/YYYY)

Is the Proposed Insured a United States citizen, or does the Proposed Insured have permanent resident *(green card)* status? ..... ☐ Yes ☐ No

If YES, and you have permanent resident status, please list your permanent resident *(green card)* number:

Does the Proposed Insured have a valid driver's license? ☐ Yes ☐ No If YES, please list state of issue and number:

2. POLICYOWNER *(Policyowner is the Proposed Insured unless otherwise indicated)*

First / Middle / Last — Legal Name	Date of Birth (MM/DD/YYYY) / /
Social Security No. — Relationship to Insured — Birth State/Country	
Street Address / City / State / ZIP+4 — Home Address	E-Mail

3. BENEFICIARIES

Primary Beneficiary Name *(First, Middle, Last)*	Relationship	Soc. Sec. No.	Date of Birth	Share %
			/ /	
			/ /	
			/ /	
			/ /	
Contingent Beneficiary Name *(First, Middle, Last)*	**Relationship**	**Soc. Sec. No.**	**Date of Birth**	**Share %**
			/ /	
			/ /	
			/ /	
			/ /	

4. PREMIUM PAYMENT MODE

Premium Payment Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly *(Automatic)* ☐ List Bill

Payor Name (First / Middle / Last)	Relationship to Insured
Billing Address (Street Address / City / State / ZIP+4)	Personal Phone No. ( )

5. GENERAL SECTION

1. In the past **2 years,** has the Proposed Insured been charged with or convicted of a felony? *(If YES, coverage cannot be issued.)*..... ☐ Yes ☐ No
2. Is the Proposed Insured currently negotiating for other insurance coverage? ..... ☐ Yes ☐ No
3. If this insurance is issued, will it replace, modify or borrow against existing or pending coverage? ..... ☐ Yes ☐ No
4. Does the Proposed Insured have other insurance coverage in force?..... ☐ Yes ☐ No
   If YES, please provide details below, and complete and return the appropriate State Replacement Form.

Name of the company _____ Policy No. _____

6. HEALTH SECTION

Section A—If any question is answered YES, coverage cannot be issued.

1. Has the Proposed Insured been medically diagnosed as having a life expectancy of **12 months** or less? ☐ Yes ☐ No

2. In the past **12 months,** has the Proposed Insured been medically diagnosed with diabetes or been treated for uncontrolled diabetes or any complications thereof, including numbness, amputation, circulation, eye or kidney disorder, coma or insulin shock; needed assistance or personal supervision to perform any activities of daily living *(toileting, transferring, continence, eating, bathing, dressing, grooming, walking, managing medications)*; had or been advised to have brain, heart or circulatory surgery; had chronic respiratory disease such as chronic obstructive pulmonary disease *(COPD)* or emphysema; been treated with oxygen; been diagnosed with heart disease or had myocardial infarction *(heart attack)* or heart-related chest pain *(angina)*; or been confined to a nursing facility or received inpatient services at a medical facility for more than 48 continuous hours? ☐ Yes ☐ No

3. Has the Proposed Insured **ever** been medically diagnosed as having or been treated for *(including office visits, medication or surgery)*: leukemia, Hodgkin's disease, a blood or bleeding disorder, connective tissue disorder, Parkinson's disease, systemic lupus erythematosus *(SLE),* amyotrophic lateral sclerosis *(ALS),* cirrhosis, chronic hepatitis B, C or D, liver disease, kidney disease with dialysis treatment, Alzheimer's disease, dementia, lymphoma, lymph node enlargement or malignant melanoma; or received or been advised to receive an organ or tissue transplant; or in the past **5 years** been medically diagnosed with or been treated for internal cancer? ☐ Yes ☐ No

4. Has the Proposed Insured been medically diagnosed as having cerebral palsy, muscular dystrophy, cystic fibrosis, sickle cell anemia, Down's syndrome or congenital heart disease? ☐ Yes ☐ No

5. Has the Proposed Insured had a medical test and not yet received the results, or been advised to have surgery or receive medical treatment? ☐ Yes ☐ No

6. Has the Proposed Insured **ever** been medically diagnosed as having or been treated by a medical professional for acquired immune deficiency syndrome *(AIDS)*, AIDS-related complex *(ARC)* or antibodies to human T-lymphotropic virus type III *(HTLV)*, or had a positive test for human immunodeficiency virus *(HIV)* antibodies? ☐ Yes ☐ No

Section B—Complete only if all answers in Sections A were NO. Any YES answers in Section B limit consideration to Graded Benefit Whole Life coverage.

1. In the past **12 months**, has the Proposed Insured been medically diagnosed as having or been treated for: congestive heart failure or cardiomyopathy, stroke, aneurysm or sleep apnea; or had or been advised to have treatment for any drug or alcohol abuse? ☐ Yes ☐ No

2. In the past **5 years**, has the Proposed Insured had heart disease requiring bypass surgery, angioplasty or placement of stents or cardiac defibrillator? ☐ Yes ☐ No

3. Has the Proposed Insured **ever** been treated for *(including office visits, medication or surgery)*: diabetes requiring insulin injections combined with a medical history of stroke, transient ischemic attack *(TIA)* or heart disease*?* ☐ Yes ☐ No

If all questions in Sections A and B are answered NO, the Proposed Insured will be considered for Level Benefit Whole Life coverage.

7. POLICY INFORMATION

Plan of Insurance: ☐ Level Benefit Whole Life ☐ Graded Benefit Whole Life Initial Death Benefit $ _____

AGREEMENT

I, *(We)* have read the above questions and answers and declare that they are complete and true to the best of my *(our)* knowledge and belief. I *(We)* agree that this application shall form a part of the policy if attached thereto.

I *(We)* agree that:

1. In the event the first full premium on the policy applied for is paid upon the date of this application, the insurance under such policy shall take effect as provided in the Temporary Conditional Insurance Agreement delivered by the Company's agent in exchange for such payment.
2. In the event the first full premium on the policy applied for is not paid upon the date of this application, the insurance under such policy shall not take effect unless: **a)** The application is approved by the Company at its home office, **b)** Such policy is issued and delivered to the Proposed Insured/Owner, and **c)** Such first full premium is paid during the Proposed Insured's lifetime and continued good health. When such approval, issue, delivery and payment have occurred, the insurance under such policy shall take effect as of the date of issue specified in the policy.
3. No agent or medical examiner is authorized or has power to change or waive any term, provision or condition of this application, the Temporary Conditional Insurance Agreement or the policy applied for, or to pass upon or approve insurability of any person for whom insurance is applied for.

Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subject to a substantial civil penalty where and to the extent allowed by state law.

Signed at _____ on _____ / _____ / _____

City *State* *Date (MM/DD/YYYY)*

_____ _____

Signature of Proposed Insured *Signature of Owner(s) (If other than Proposed Insured)*

FIELD UNDERWRITER'S STATEMENT

Please answer the following questions:

1. a. What amount was collected with this application? $ _____

   b. Has a Temporary Conditional Insurance Agreement been given to the Policyowner? ☐ Yes ☐ No

   c. Has the Proposed Insured signed a Confidential Information Authorization and been given a Consumer Notice? ☐ Yes ☐ No

2. a. Did you personally see the Proposed Insured on the date of application? ☐ Yes ☐ No

   b. How well do you know the Proposed Insured? ☐ Well ☐ Slightly ☐ Not at all

   c. Are you aware of anything about the health, habits, hobbies or mode of living which might affect the insurability of the Proposed Insured? ☐ Yes ☐ No

   If YES, please provide details _____

3. a. If this insurance is issued, will it replace, modify or borrow against existing or pending coverage? ☐ Yes ☐ No

   b. Does the Proposed Insured have other insurance coverage in force? ☐ Yes ☐ No

4. Are commissions to be split? ☐ Yes ☐ No Agent No. _____ _____% Agent No. _____ _____%

AUTOMATIC PAYMENT OPTIONS

☐ Set up NEW bank withdrawal—signed authorization and voided check attached with the application.

☐ Add to existing bank withdrawal; indicate other applicant and/or policy numbers _____

☐ Set up NEW credit card payment—signed authorization attached with the application.

LIST BILL

☐ Set up NEW list bill—signed authorization attached with the application.

☐ Add to existing list bill; indicate list bill no. _____ and/or name of company _____

I hereby certify that to the best of my knowledge and belief, the answers on the application and in this statement are true and correct.

_____	/ /	( ) / ( )
Signature of Soliciting Agent	*Date (MM/DD/YYYY)*	*Business Phone No. and Fax No.*
_____	_____	_____
Soliciting Agent's Printed Name	*Agent No.*	*Agent's E-mail*
_____	/ /	( )
Signature of Second Soliciting Agent (if split commission)	*Date (MM/DD/YYYY)*	*Agent No.* *Business Phone No.*

SERFF Tracking Number:	*SEFL-126359476*	*State:*	*Arkansas*
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Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification
Comments:
Attachment:
READ CERT.pdf

Item Status: **Status Date:**

Bypassed - Item: Application
Bypass Reason: N/A
Comments:

Item Status: **Status Date:**

Bypassed - Item: Life & Annuity - Acturial Memo
Bypass Reason: N/A
Comments:

READABILITY CERTIFICATION

I hereby certify the following forms were tested for readability using Microsoft® Word XP program and achieved the following test results:

Company Name: Assurity Life Insurance Company

Form Number(s): **47-300-01101 (R10-09)**

Type of Form: Life

Form No.	Description	Flesch Score
47-300-01101 (R10-09)	Application for Simplified Life Insurance	50.5

Carol S Watson
Signature

November 4, 2009
Date

Carol Watson
Vice President, General Counsel and Secretary